

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

03671

96

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Cecil

County

Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Agnes Jackson Atkinson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White

Married

6. (b) Name of husband or wife

George A. Atkinson

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 11, 1867

8. AGE:

Years
78Months
6Days
30

It less than one day

hrs.

min.

9. Birthplace

Perryville, Cecil Co., Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Samuel Jackson

MOTHER

Cecil County

FATHER

Mary Agnes Richardson

MOTHER

Cecil County

FATHER

George A. Atkinson

16. Informant

Port Deposit, Md.

Address

Burial Date thereof 4-13-46

(Burial, cremation, or removal. Which?)

Cemetery or crematory Hopewell Cemetery

Location

Port Deposit, Rural, Md.

18. Funeral director

Lee A. Patterson & Son

Address

Box 157, Perryville, Md.

19. (Date rec'd by registrar)

April 13 1946 - June 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Cecil

City or town Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 10 1946 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June - 18 1945, to April 10 - 1946,

and that I last saw her alive on April 10 - 1946.

Immediate cause of death

Cerebral Hemorrhage
(Paralysis Right side)

Due to Arterio-Sclerosis

Hypertension -

Due to

DURATION

6 months

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

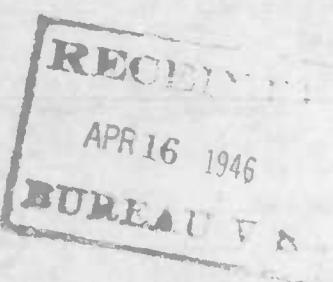
Injured at work?

23. SIGNATURE

B. Johnson, M.D.

M. D. or other

Address Port Deposit, Md. Date signed 4-11-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-50

03672

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....

City or town.....

Cecil
Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Helen Edna Boatman

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*F**White**Single*

6. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)

6. (c) If alive, give age.....

years

Jan 1 1929

8. AGE:

Years

Months

Days

If less than one day

*17**4**15*

hrs.

min.

9. Birthplace.....

Baltimore Md.

(Town, county, and state)

10. Usual occupation.....

Homemaker

11. Industry or business.....

MOTHER FATHER

12. Name.....

Helen Boatman

13. Birthplace

Wellsboro Pa

14. Maiden name.....

Alice Lofield

15. Birthplace

Dunbar

16. Informant.....

Frank Boatman

Address

Elkton Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....

(Month) (day) (year)

Cemetery or crematory.....

Mt. Zion CHURCH

Location.....

FAIRFIELD, Pa

18. Funeral director.....

H.W. Pippin

Address

ELKTON, Md.

19. Date rec'd by registrar.....

(Date rec'd by registrar)

JR Frager

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Cecil

City or town.....

Elkton

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 16 1946

19... at ...

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..., to ..., 19...

and that I last saw h... alive on

Immediate cause of death.....

6 a.m.
Guillain-Barre syndrome
Accordinging

DURATION

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Suicide

Date of ...

Where did injury occur?

Elkton

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

home

Means of injury.....

Injured at work?

Medical Examiner

Social County

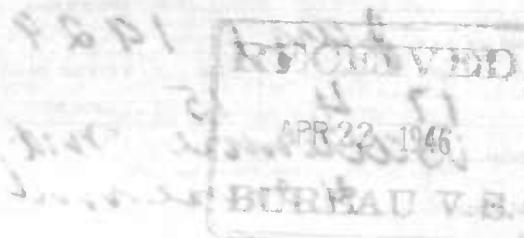
23. SIGNATURE.....

M. D. or other

*J. E. Hodson MD**Residing Sun Md*

Date signed

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W.H.A. Manuscript

Manuscript

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

03673

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

27 days

Hospital, Institution, or street address where death occurred:

Union Hospital Ellicott

How long in hospital or institution?

21 days

3. (a) FULL NAME

Joseph Boddy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. Col. Widower

6. (b) Name of husband or wife

Frannie Boddy

7. Birth date of deceased (mo., day, yr.)

April 19 1863

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

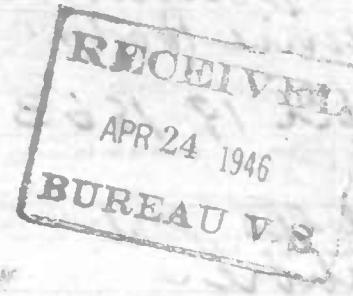
FATHER

MOTHER

MOTHER

FATHER

MOTHER</



PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1248

03674

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH:

County.....Cecil
 City or town.....Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....43

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William M Brown

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleWhite married6.(b) Name of husband or wife.....Anna Ayers Brown

7. Birth date of deceased (mo., day, yr.)

April 17 - 19566.(c) If alive, give age 71 years

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>-</u>	<u>2</u>	<u>hrs.</u>
			<u>min.</u>

9. Birthplace.....

Salem N.J.

(Town, county, and state)

10. Usual occupation.....

Summer Dealer

11. Industry or business.....

Petrol 1 year

MOTHER FATHER

12. Name.....

William M. Brown

13. Birthplace.....

New Jersey

14. Maiden name.....

Waddington

15. Birthplace.....

New Jersey

16. Informant.....

Mrs Joseph A. Hart

Address

Chesapeake City

17. Burial (Burial, cremation, or removal. Whence)

BethelDate thereof 4-21-46
(month) (day) (year)

Cemetery or crematory.....

Bethel

Location.....

Chesapeake City Rural Reg.

18. Funeral director.....

Joseph A. Hart

Address

North Cash Rd

19. Date rec'd by registrar

April 20th 1946 Mrs. Bessie D. Bell

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MD County.....CecilCity or town.....Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....not a Veteran3.(b) Social Security Number 213-01-9063

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Opie 19 1946, at 6:50 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1942, to Opie 19 1946, and that I last saw him alive on Opie 19 1946.

Immediate cause of death.....

Gmbobon of lungsDue to.....Chronic Hepatitis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

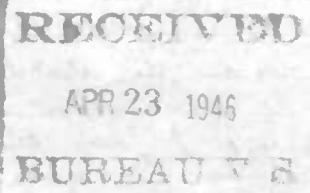
Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....H. J. Davis MD M. D. or other.....Address.....Chesapeake City Date signed 4/19/46



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No.

03675

96

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Angelina Cifaldo

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb. 7, 1886

8. AGE:

Years

Months

Days

If less than one day

60

2

13.

hrs. min.

9. Birthplace.....

(Town, county, and state)

Italy

10. Usual occupation.....

Laborer

11. Industry or business

Stone Quarry

12. Name.....

Dominic Cifaldo

13. Birthplace.....

Italy

14. Maiden name.....

Unknown

15. Birthplace.....

Italy

16. Informant.....

Dominic Cifaldo

Address.....

Port Deposit, Md.

17. Burial.....

Burial

Date thereof..... April 23, 1946
(month) (day) (year)

Cemetery or crematory.....

Brookview

Location.....

Paging Swan, Md.

18. Funeral director.....

Lyle A. Patterson & Son

Address.....

Perryville, Md.

19. April 22

19. Be drama & language

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 20, 1946, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Acute

Coronary

Due to.....

Thrombosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

R. L. Hodgeson, M.D.
Reservy Secured 4/20/46

M. D. or other

Date signed

RECEIVED

APR 24 1946

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46d

03676

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County CecilCity or town Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ann Dora Conner

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Oliver W. Conner

7. Birth date of deceased (mo., day, yr.)

Oct 18, 1873

8. (c) If alive, give age years

8. AGE:

Years
72Months
5Days
6

It less than one day

hrs.

min.

9. Birthplace

Slanardan Pa

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

None

FATHER

12. Name

Henry Lewis

MOTHER

13. Birthplace

Penn.

14. Maiden name

Dora Foy

15. Birthplace

Penn

16. Informant

Mrs Martha Rogers

Address

Rising Sun, md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

April 27, 1946

(month)

(day)

(year)

Cemetery or crematory

Friends

Location

Calvert, Md.

18. Funeral director

Ralph M Reed

Address

Rising Sun, md.

19. (Date rec'd by registrar)

Apr 26 1946

19.

Registrar

Lynn Washington

Permit issued

Apr 26 1946

19.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Rising Sun (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Between Farmers & Calvert

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 24 1946

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

March 1 1945 to April 23 1946and that I last saw her alive on 4/23 1946

Immediate cause of death

Decay of heart

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

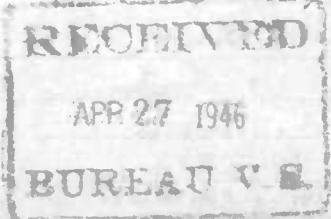
Lev Dodson Jr.

M. D. or other

Rising Sun Md

Date signed

4/25/46



PLEASE WRITE PLAINLY, WITH UNTADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

03677
Reg. Dist. No. 94

1. PLACE OF DEATH

County

City or town

Cecil

North East, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Rachel Ann Ferguson

3. (b) Social Security Number

None

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White Widowed

6. (b) Name of husband or wife

Henry Ferguson

7. Birth date of deceased (mo., day, yr.)

Aug 12 1867

(c) If alive, give age

years

8. AGE:

Years Months Days If less than one day

78

8

7

hrs.

min.

9. Birthplace

North East, R. D.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Thos. B. McKinney

MOTHER

13. Birthplace

Md

14. Maiden name

Elizabeth Mahoney

15. Birthplace

Md

16. Informant

Andrew Ferguson

Address

North East, Md.

B. w. ral.

Date thereof

Apr 23, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Methodist

Cemetery or crematory

North East, Md.

Location

Joseph - R. Street

Address

North East, Md.

19. 4/23

19. 46

Lead & Drums

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Cecil

City or town

North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

-

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 19 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr - 19 1946 to Apr - 19 1946

and that I last saw her alive on Apr - 19 1946

Immediate cause of death

Cerebral

exclerosis

DURATION

1 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

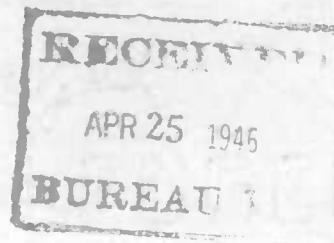
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. B. Blaeris M. D. or other

Address North East, Md. Date signed 4-22-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12

03678

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. Col Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

4 21 hrs. min.

9. Birthplace: Middletown, Md., U.S.A. (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

FATHER

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 25, 1946
(month) (day) year

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

19..... to.....

18.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

Bronchitis

DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Autopsy results..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

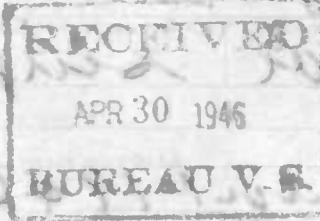
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

Other.....

23. SIGNATURE.....

Witnessed by..... Date signed.....



(I)

VS A16 9-45-15 M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BD*

03679

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County... CecilCity or town... Perry Point, Maryland. Veterans Admini
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

3. (a) FULL NAME

FURLONG, Raymond B.

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Mrs. Grace M. Furlong6.(c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.)

8-18-97

8. AGE:

48

Years

Months

Days

If less than one day

..... hrs. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Banker

11. Industry or business

-

12. Name Phillip J. Furlong13. Birthplace Maryland14. Maiden name Anne Coffey15. Birthplace Maryland

16. Informant

Hospital Records

Address

Veterans Administration, Perry Point, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 4-9-46

(month) (day) (year)

Cemetery or crematory

St. Mary's Cemetery

Location

St. Mary's, Pa.

18. Funeral director

Pennington & Son

Address

Hayre de Grace, Md.

19. Date rec'd by registrar

Apr. 91946Jane Daugherty

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County -City or town Baltimore, Md. (If outside city or town limits, write RURAL and give nearest town)Street No. 2228 Calvert Street (If rural, give LOCATION)2.(a) If veteran, name war WW II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9

19 46 at 12:05P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 19 46 to April 9 19 46

and that I last saw him alive on April 9 19 46

Immediate cause of death Myocardial Degeneration DURATION UnknownDue to Coronary Arteriosclerosis UnknownDue to Pleurisy, with effusion Unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

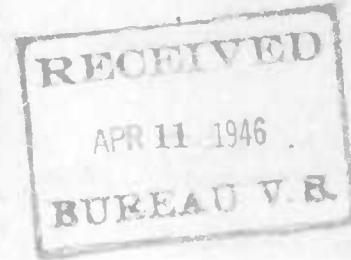
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE A. E. Trollingen, M.D. Clinical Director
A. E. TROLLINGER, M.D. Clinical Director
acting for the Manager, Veterans Administration
Address Perry Point, Md. Date signed 4-9-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03680

94

Reg. Dist. No.

1. PLACE OF DEATH

County

City or town

Baltimore
North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 days.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Julio & Gonzalo g.

4. Sex

M

5. Color or race

White

6.(a) Single, married, widowed, or divorced

—

6.(b) Name of husband or wife

—

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

Years Months Days If less than one day
40 — — hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation

no regular formation

11. Industry or business

—

FATHER

12. Name

—

13. Birthplace

—

MOTHER

14. Maiden name

—

15. Birthplace

—

16. Informant

Henry Harvey

Address North East Md

Burial Date thereof April 16-46

(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory County

Location Cherry Hill Md

18. Funeral director Joseph P. Ghan

Address North East Md

19. 4/16/46 Date rec'd by registrar

Address Lydia V. Greene

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

058-22-1780

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 7 1946 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19...

to 19...

and that I last saw h. alive on

19...

Immediate cause of death

acute coronary

Due to

Thrombosis

DURATION

Due to

Other conditions

(Indicate pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

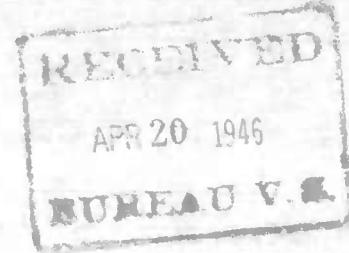
Means of injury Injured at work?

Medical Examiner for Cecil County

23. SIGNATURE M. D. or other

Address

Date signed 4/16/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13 (B)

CERTIFICATE OF DEATH

0368192
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Cecil

City or town.....

Rural Elkton R.D. 4

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*49 years*Hospital, institution, or street address where death occurred:.....*Elkton R.D. 4*

How long in hospital or Institution?.....

3. (a) FULL NAME

Margaret Gross

4. Sex

F-

5. Color or race

wh.

6.(a) Single, married, widowed, or divorced

Single.

6.(b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

February 7, 1870

6.(c) If alive, give age

years

8. AGE:

Years
*76*Months
*1*Days
28

If less than one day

hrs. min.

9. Birthplace.....

Delaware
(Town, county, and state)

10. Usual occupation.....

at Home

11. Industry or business

MOTHER FATHER

12. Name.....*Thomas B. Gross*

13. Birthplace

*Pa*14. Maiden name.....*Elizabeth Hand*

15. Birthplace

*Delaware*16. Informant.....*Anna Rebecca Gross*

Address

Elkton R.D. 4, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....*Apr 9/46*
(month) (day) (year)Cemetery or crematory.....*Union*Location.....*Elkton R.D. 4, Md*18. Funeral director.....*H.W. Pappin*

Address

Elkton, Md

19. Date rec'd by registrar

(Date rec'd by registrar)

*April 9 1946**H.F. Fraser*
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md*

County.....

*Cecil*City or town.....*Rural near Elkton*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....*R.D. 4*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*April 5* 1946 at 10⁰⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 28 1946 to *April 5* 1946and that I last saw her alive on *April 2* 1946

Immediate cause of death.....

Cardio-vascular - renal disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....*Dr. Ford H. Sprecher, M.D.*

M. D. or other

Address.....*Elkton, Md* Date signed.....*April 8*

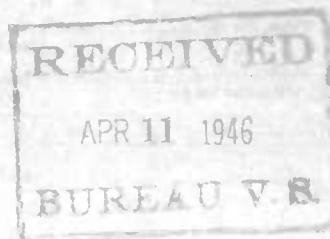
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

Reg. Dist. No. 03682

1. PLACE OF DEATH:
County.....Cecil
City or town.....Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital, Elkton, Md.

How long in hospital or institution?

3 Days

3. (a) FULL NAME

Helen J. Heisler

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife.....Joseph M. Heisler7. Birth date of deceased (mo., day, yr.).....Oct 15 18846.(c) If alive, give age.....64 years8. AGE: Years Months Days If less than one day
61 5 16 hrs. min.9. Birthplace.....North East Cecil Co. Md.

(Town, county, and state)

10. Usual occupation.....Housewife

11. Industry or business

12. Name.....William C Clark13. Birthplace.....Maryland14. Maiden name.....Helen M. Murdoch15. Birthplace.....Maryland16. Informant.....Joseph R. GrantAddress.....North East. Md17. Burial.....Burial Date thereof.....April 4 1946
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....MethodistLocation.....North East. Md18. Funeral director.....Joseph R. GrantAddress.....North East. Md.19. Date rec'd by registrar.....Apr 4 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State.....Md County.....CecilCity or town.....North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....April 1 1946 at 8:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1946, to April 1, 1946, and that I last saw her alive on April 1, 1946.

Immediate cause of death.....

Cerebral EmbolismDue to.....Pancreatitis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....D. A. Cummins M.D.

M. D. or other

Address.....North East. Md. Date signed.....Apr 3/46

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APR 11 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore No. 8

63683

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County *Cecil*City or town *Elkton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *25 yrs.*

Hospital, institution, or street address where death occurred:

E Main St.

How long in hospital or institution?

3. (a) FULL NAME

Evelyn C. Howard

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

F. wh. Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *December 29, 1866*

6.(c) If alive, give age years

8. AGE: Years *79* Months *5* Days *0* If less than one day
hrs. min.9. Birthplace *Elkton*
(Town, county, and state)10. Usual occupation *at home*

11. Industry or business

MOTHER FATHER 12. Name *H. H. M. Howard*13. Birthplace *Elkton, Md*14. Maiden name *Lovinia Howard*15. Birthplace *Elkton, Md*16. Informant *Morion R. McCarty*Address *110 Bow St Elkton Md*17. Burial *Burial* Date thereof *May 2/46*
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory *Elkton Cent*Location *Elkton Md*18. Funeral director *H. W. Pippins*Address *Elkton, Md*19. Date rec'd by registrar *May 1 1946*(Date rec'd by registrar) *J. R. Fraser*
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Cecil*City or town *Elkton, Md*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *E Main St.*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 29 1946* at *90* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *April 22 1946* to *April 29 1946*and that I last saw her alive on *April 29 1946*Immediate cause of death *Pneumonia* DURATION *7 days*Due to *Being chilled while riding in an automobile*Due to *Chronic cholecystitis, cystitis*Other conditions *Include pregnancy within 3 months of death*

Major findings or operations Date of op.

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

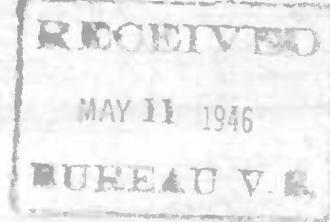
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Dr. R. Morison, M.D.* M. D. or otherAddress *Elkton, Md* Date signed *4-30-46*

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B-6*

CERTIFICATE OF DEATH

03684

Reg. Dist. No. 95

1. PLACE OF DEATH:

County.....

City or town.....

*Georgetown**Rural*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

George Washington Remond

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M**White**Maurice*

6. (b) Name of husband or wife.....

Catherine Remond

7. Birth date of deceased (mo., day, yr.)

June 12 1858

78 years

8. AGE:

Years

88

9

Months

Days

8

If less than one day

hrs.

min.

9. Birthplace.....

Stanford City Md.

(Town, county, and state)

10. Usual occupation.....

Lawyer

11. Industry or business

*Jacob Remond**England*

12. Name.....

Azora Griffith

13. Birthplace.....

Leyton Co. Eng.

14. Maiden name.....

Catherine Remond

15. Birthplace.....

Georgetown Md.

16. Informant.....

Catherine Remond

17. Address.....

Georgetown Md.

Burial

Date thereof *April 7 1886*

(Burial, cremation, or other)

(month) (day) (year)

Which

Cemetery or cemetery.....

Int Pleasant

Location.....

Collegiate Md.

18. Funeral director.....

J.C. Tysor

Address.....

Rising Sun Md.

19. Date rec'd by registrar.....

Apr 6 1886

19.

Date rec'd by registrar

Apr 6 1886

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Georgetown

City or town.....

Georgetown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 5 1886

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19.....

to.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

*Chronic Grippe exanthem.*Duration: *Two months*

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

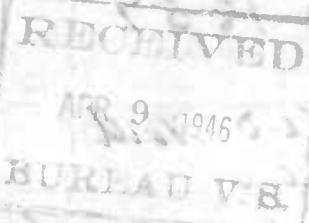
23. SIGNATURE.....

*John Dolan M.D.*Medical Examiner
for County of

M. D. or other

Address.....

*Rising Sun Md.*Date signed *4/15/86*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 840

03685

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH

CECIL

County

VETERANS ADMINISTRATION PERRY POINT,

City or town

(If outside city or town limits, write RURAL and give nearest town)

Md.

How long in above place of death?

1 month, 14 days

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution?

Same as above

3. (a) FULL NAME

LILLY, David G. Jr.

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

11-21-1908

8. AGE:

37

Years

Months

Days

It less than one day

— hrs. — min.

9. Birthplace

Charleston, W. Va.

(Town, county, and state)

10. Usual occupation

Attorney

11. Industry or business

—

MOTHER FATHER

12. Name

David Green Lilly

13. Birthplace

Summers County, W. Va.

14. Maiden name

Nellie McGinnis

15. Birthplace

Raleigh County, W. Va.

16. Informant

Hospital Records

Address

Veterans Administration, Perry Point, Md.

17. Removal

Date thereof

1-25-46
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Sunset Memorial Cemetery

Location

Kanowha County, Charleston, W. Va.

18. Funeral director

Pennington & Son

Address

Havre de Grace, Md.

19. Date rec'd by registrar

April 25, 1946

(Date rec'd by registrar)

Irene E. Daugherty

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

W. Va.

County

Kanowha County

City or town

Charleston

(If outside city or town limits, write RURAL and give nearest town)

Street No.

2226 Washington Street

(If rural, give LOCATION)

2.(a) Is veteran, name war

W.W.I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 25

1946

at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11

1946

to April 25, 1946

and that I last saw him alive on April 25, 1946

Immediate cause of death

malnutrition and exhaustion

DURATION

over 1 mo.

Due to Manic Depressive Psychosis, over 1 mo.

Manic Type

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

not performed

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

G. CLARKE, M.D., Manager, Veterans Administration, Perry Point, Md.

M.D. or other

Address

Date signed

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

03686

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County.....

Cecil

City or town.....

Coronado, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

11 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Laura Jane Jan

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife.....

B.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Nov. 17 1852

8. AGE:

93

Years

5

Months

Days

13

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Cecil Co. Md.

10. Usual occupation.....

Housework

11. Industry or business

MOTHER FATHER

12. Name.....

Name.....

13. Birthplace

Unknown

Name.....

Name.....

14. Maiden name.....

Name.....

15. Birthplace

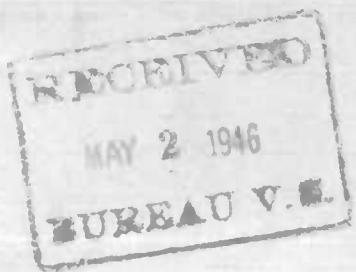
Unknown

Name.....

Name.....

16. Informant.....

Name.....



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BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

13688 96

Reg. Dist. No.

1. PLACE OF DEATH: Leesburg
 County
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 minutes
 Hospital, Institution, or street address where death occurred:

 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Leesburg
 City or town Leesburg (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

3. (a) FULL NAME: William M. Morrison

4. Sex: <u>M</u>	5. Color or race: <u>White</u>	6. (a) Single, married, widowed, or divorced: <u>Married</u>
6. (b) Name of husband or wife: <u>Marion Angell Morrison</u>		
7. Birth date of deceased (mo., day, yr.): <u>July 27, 1895</u>		
8. AGE: Years <u>59</u> Months <u>8</u> Days <u>12</u> If less than one day hrs. min.		
9. Birthplace: <u>Leesburg, Cecil Co., Md.</u> (Town, county, and state)		
10. Usual occupation: <u>Guard</u>		
11. Industry or business: <u>Susquehanna Electric Co.</u>		
12. Name: <u>Granville Morrison</u>		
13. Birthplace: <u>Cecil Co., Md.</u>		
14. Maiden name: <u>Julia Simmers</u>		
15. Birthplace: <u>Cecil Co., Md.</u>		
16. Informant: <u>Marion A. Morrison</u>		
Address: <u>Leesburg, Md.</u>		
17. Burial: <u>Burial</u> Date thereof: <u>April 11, 1946</u> (Burial, cremation, or removal. Which? (monthly) (day) (year))		
Cemetery or crematory: <u>West Nottingham</u>		
Location: <u>Leesburg, Md.</u>		
18. Funeral director: <u>Lee A. Patterson & Son</u>		
Address: <u>Perryville, Md.</u>		
19. Date rec'd by registrar: <u>April 11, 1946</u> Signature: <u>Irene E. Daugherty</u> VS A15 Register		

3. (b) Social Security Number: 216-01-7729

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1946, at 10a.m.

I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.
and that I last saw him alive on 19.

Immediate cause of death: Acute Bronchitis DURATION

Due to: Thrombosis

Due to:
.....

Other conditions:
.....

(Include pregnancy within 3 months of death)

Major findings or operations:
.....

Date of op.:
.....

Autopsy results:
.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 Address: W. LeDockett Jr. Date signed: April 11, 1946 M. D. or other: Cecil County

23. SIGNATURE: W. LeDockett Jr. M. D. or other: Cecil County
Address: Leesburg, Md. Date signed: April 11, 1946

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SEARCHED INDEXED
SERIALIZED FILED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

93689

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....

City or town.....

Serial
Clinton Jail Elkton Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Cecil County Jail

How long in hospital or institution?

3. (a) FULL NAME

John Murray

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business.....

FATHER

12. Name..... Joseph Murray

MOTHER

13. Birthplace..... Ireland

14. Maiden name..... Mary Donally

15. Birthplace..... Ireland

16. Informant..... Mrs. Ellen Murray

Address

154 W. Main St Port Deposit.

Burial

(Burial, cremation, or removal. Which?)

Date thereof Apr. 27/46

(month) (day) (year)

Cemetery or crematory.....

Mt. Erie Catholic

Location.....

Hause de Grace

18. Funeral director..... H. W. Lippin

Address

Elkton, Md

19. Apr. 26 1946

(Date rec'd by registrar)

J. R. Fraser

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 24 1946 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw him..... alive on.....

19.....

Immediate cause of death.....

Cerebral
Myocarditis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

A. H. D. Jackson, M.D. Cecil County

Signature

M. D. or other

Address..... Date signed..... Apr. 26 1946

RECEIVED

MAY 1 1948

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore No.

03690

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH:

Cecil

County

Bainbridge, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 20 days

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, NTC, Bainbridge, Md.

How long in hospital or institution? 1 month 21 days

3. (a) FULL NAME

PICCIRILLO, Anthony Dominick

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.) 1-25-28

8. AGE: Years Months Days If less than one day
18 2 19 .hrs. .min.

9. Birthplace Troy, New York

(Town, county, and state)

10. Usual occupation USN

11. Industry or business

12. Name John Piccirillo

13. Birthplace Italy

14. Maiden name Mary Fuscop

15. Birthplace Italy

16. Informant Records Office, U.S. Naval Hosp.

Address Bainbridge, Maryland

17. Removal Date thereof 4-16-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's

Location Troy, New York

18. Funeral director Lee A. Patterson & Son

Address Perryville, Maryland

19. April 16 1946 Ira E. Daugherty
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

New York

State County

Troy

(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Hutton St., Troy, N. Y.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 April 1946 at 1:01 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 February 1946 to 14 April 1946

and that I last saw him alive on 14 April 1946

Immediate cause of death Glomerulo-nephritis

Acute

DURATION 80 days.

Due to.....

Due to.....

Other conditions Sub-acute bacterial endocarditis

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results confirmed above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

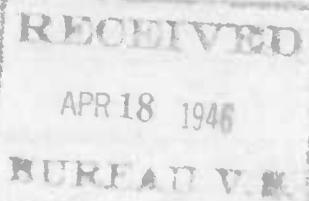
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature HARRY C. OARD, CAPT. (MC) USNR
M. D. or other

Address USNH, NTC, Bainbridge, Md. Date signed 4-15-46



Evidence for the change
of age of deceased is
shown on

FILM No. I 04 JUN - 6 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

63691

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....

Cecil

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 days

Hospital, Institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?.....

3 1/2 days

3. (a) FULL NAME

Richard Edward Reynolds

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widower

6. (b) Name of husband or wife.....

Margaret

7. Birth date of

deceased (mo., day, yr.)

Jan 26 1868

8. AGE:

Years

Months

Days

If less than one day

78

17 6 2

22

hrs. min.

9. Birthplace.....

North East, Cecil Co Md

(Town, county, and state)

10. Usual occupation.....

Retired Ship Carpenter

11. Industry or business

FATHER

12. Name.....

Richard Reynolds

MOTHER

13. Birthplace

Md

MOTHER

14. Maiden name.....

Martha Donohue

MOTHER

15. Birthplace

Md

16. Informant.....

See W. Alton

Address

C Chesapeake City Md

Burying

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal which?)

Apr 20 46

Cemetery or crematory.....

Bethel

Location.....

C Chesapeake City Rural

18. Funeral director.....

Joseph P. Gandy

Address

North East Md

April 20 46

LH Fraser

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Cecil

City or town.....

C Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

World War

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

4/17 1946 at 7:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 12

1946

to April 17

1946

and that I last saw him alive on

April 16

1946

Immediate cause of death.....

Hypertension Cancer

cancer

several pals

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

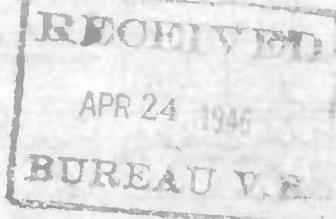
23. SIGNATURE

H. D. Doris MD

M. D. or other

Address..... Date signed.....

Chesapeake City Md 4/19/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 302

03692

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... CECIL

City or town..... Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 2 mo.

Hospital, Institution, or street address where death occurred:

Veterans Administration, Perry Point, Maryland.

How long in hospital or institution? 2 years 2 months

3. (a) FULL NAME

TEAT, Ollie H.

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mae Teat

6.(c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) August 2, 1892

8. AGE: Years Months Days If less than one day
53 8 8 hrs. min.9. Birthplace Bridgetown, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business —

12. Name Jim Teat

13. Birthplace Maryland

14. Maiden name Mandie Thomas

15. Birthplace Maryland

16. Informant Hospital records

Address Veterans Administration, Perry Point, Md.

17. Removal Date thereof 11-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Denton Cemetery

Location Greensboro, Caroline County, Md.

18. Funeral director Trollingen & Son

Address Havre de Grace, Md.

19. April 11, 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline
Denton

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war WW I

3. (b) Social Security Number

O

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10

19 46 at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10, 1944, to April 10, 1946, and that I last saw him alive on April 10, 1946.

Immediate cause of death

Syphilis of the Central Nervous System, tabo-paretic type

Over 4 yrs.

Due to

Due to

Other conditions Psychosis with syphilis of the Central Nervous System, tabo-paretic type. Over 4 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

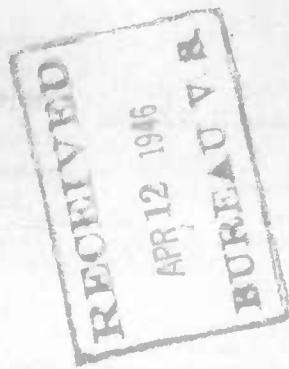
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURES A.E. TROLLINGER, M.D. Clinical Director M.D. another

Address Acting for the Nameless Date signed April 10, 1946
Veterans Administration, Perry Point, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

63693

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
Cecil County
City or town Bainbridge, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Mass. County
City or town Gill
(If outside city or town limits, write RURAL and give nearest town)
Street No. South Cross Road
(If rural, give LOCATION)
2.(a) If veteran, name war World War 2.

3. (a) FULL NAME
TUTTLE, Philip Bates

4. Sex M.	5. Color or race W	6. (a) Single, married, widowed, or divorced S.
--------------	-----------------------	--

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) September 27, 1924.
B. (c) If alive, give age years

8. AGE: Years 21	Months 6	Days 8	If less than one day hrs. min.
---------------------	-------------	-----------	--

9. Birthplace MASSACHUSETTS
(Town, county, and state)

10. Usual occupation U.S. NAVY.

11. Industry or business

12. Name Arthur Edmond Tuttle
13. Birthplace Unknown

MOTHER FATHER	Mary Tuttle
14. Maiden name	Unknown
15. Birthplace	

16. Informant Records Office, U.S. Naval Hosp
Bainbridge, Maryland
Address

17. Burial Removal Date thereof April 7, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Riverside Cemetery
Location Gill, Mass.

18. Funeral director The Patterson & Son
Address Perryville, Md.

19. April 7, 1946 Irene E. Daugherty
(Date rec'd by registrar) Registrar

3. (b) Social Security Number
027-16-9122

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 APRIL 1946 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 APRIL, 1946, to Death 1946, and that I last saw him alive on 5 April, 1946.

Immediate cause of death Asphyxiation by respiratory obstruction of bronchi.

Due to Fracture simple, left femur.
Received in motorcycle-auto accident.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op. 4-5-46

Autopsy results Above findings At Autopsy.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4-2-46

Where did injury occur? Rt. #1 -near Poplar grove, Md.

(City or town) (County) (State)

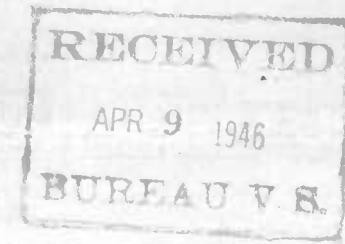
Injured at home, farm, industry, public place (where?) On highway.

Means of Injury Injured at work?

Charles J. Berg

23. SIGNATURE Charles F. Berg, Comdr. (MC) USNR

Address Bunker Hill, Md. Date signed 4-6-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

03694

Reg. Dist. No.

94

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

City or town.....*Cecil*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*25*

Hospital, Institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

William H. Ulary

3. (b) Social Security Number

218-14-8669

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*Male White Married*6.(b) Name of husband or wife.....*F. Florence Ulary*6.(c) If alive, give age.....*70* years

7. Birth date of deceased (mo., day, yr.)

June 13 1876

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace.....

(Name, county, and state).....*North East Rural*

10. Usual occupation.....

Stationary Engineer

11. Industry or business

12. Name.....*Charles Ulary*13. Birthplace.....*Sandston, Virginia*14. Maiden name.....*Annie Wilson*15. Birthplace.....*Md*16. Informant.....*F. Florence Ulary*Address.....*North East Rd 20 Md*17. Burial Date thereof.....*April 29, 1946*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....*Methodist*Location.....*North East Md*18. Funeral director.....*Joseph P. Grant*Address.....*North East Md*19. (Date rec'd by registrar).....*4/29/46* 19.....*46* Sada & Evans

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md*

County.....

City or town.....*North East Rural*

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war.....*World War**not a veteran*

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 26 1946 at 1230 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw h.....alive on..... 19.....

Immediate cause of death.....

*Acute**leorvency**fluorobacis*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

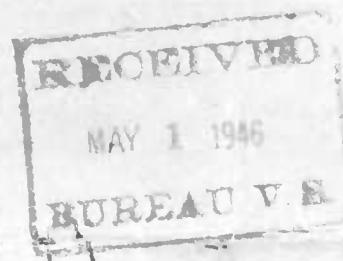
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

Medical Examiner
John W. Rodson, M.D. or Cecil CountyM. D. or other
Address.....*Rising Sun Md* Date signed.....*4/27/46*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19102

CERTIFICATE OF DEATH

15695
95

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

Name.....

How long in hospital or Institution?.....

3. (a) FULL NAME

Stewart McClelland Ward-

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife.....

Emily D Ward-

7. Birth date of

deceased (mo., day, yr.)

Feb 10 - 1883

6.(c) If alive, give age.....

years

8. AGE:

Years

Months

Days

If less than one day

63

2

.....

hrs. min.

9. Birthplace.....

Pittsburgh Pa

(Town, county, and state)

10. Usual occupation.....

Merchant

11. Industry or business

William H Ward

12. Name.....

Pittsburgh

13. Birthplace

14. Maiden name.....

Sara Stewart

15. Birthplace

Pittsburgh

16. Informant.....

Emily D Ward

Address

Rising Sun, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

West Baltimore Cemetery

Location

Colorado Md.

18. Funeral director.....

J. E. Lyon.

Address

Rising Sun Md.

19. Date issued

19

20. Last signed

APR 29 1944

21. Last signed

APR 29 1944

22. Last signed

APR 29 1944

23. Last signed

APR 29 1944

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APR 29 1944

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146. Last signed

APR 29 1944

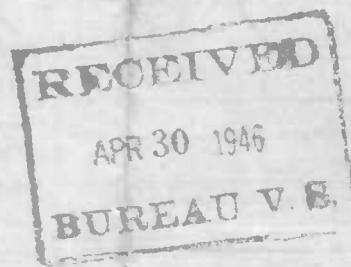
147. Last signed

APR 29 1944

148. Last signed

APR 29 1944

149. Last signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

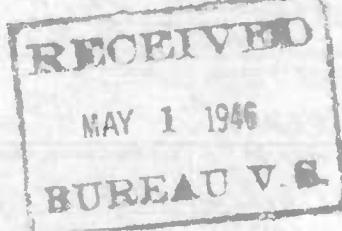
2411 N. Charles St., Baltimore (312)

CERTIFICATE OF DEATH

Reg. Dist. No.

03695 94
Diat. No.

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)		
New long in above place of death?..... Hospital, institution, or street address where death occurred:..... How long in hospital or institution?.....			Street No. (If rural, give LOCATION)		
3. (a) FULL NAME <i>William T. Weaver</i>			2.(a) If veteran, name war..... 3. (b) Social Security Number <i>none</i>		
4. Sex <i>Male</i> <input checked="" type="checkbox"/> <i>Widely married</i> 5. Color or race <i>White</i>			6. (a) Siegle, married, widowed, or divorced <i>Married</i>		
6. (b) Name of husband or wife..... <i>Elizabeth Weaver</i>			6. (c) If alive, give age..... <i>84</i>		
7. Birth date of deceased (mo., day, yr.) <i>Feb. 12, 1868</i>			8. AGE: Years Months Days If less than one day <i>78 2 14 hrs. min.</i>		
9. Birthplace..... <i>Bearano Hill Cecil Co Md</i> (Town, county, and state)			10. Usual occupation..... <i>Merchant</i>		
11. Industry or business <i>General Weaver</i>			12. Name..... <i>Wm. T. Weaver</i>		
13. Birthplace <i>Md</i>			14. Maiden name..... <i>Annie E. Patterson</i>		
15. Birthplace <i>Md</i>			16. Informant..... <i>Agnes Weaver</i>		
17. Address..... <i>North East Rd 2 Mo</i>			18. Date of death..... <i>Aug 30-1946</i> (Burial, cremation, or removal? Which?) Cemetery or crematory..... <i>Elkton Rural Union</i> Location..... <i>Elkton Royal</i>		
19. Funeral director..... <i>Joseph P. Gray</i>			Address..... <i>North East Rd</i>		
20. Date rec'd by registrar..... <i>4/29/46</i>			21. M. D. or other Date signed..... <i>4-27-46</i>		
MEDICAL CERTIFICATION					
20. DATE OF DEATH..... <i>April 26 1946</i> , at..... 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... <i>Mar 22 1946</i> to <i>April 26 1946</i> , and that I last saw him alive on <i>April 26 1946</i> .					
Immediate cause of death..... <i>General arterio sclerosis</i>					
Due to..... <i>Cardio vascular renal complication</i>					
Due to..... <i>Cerebral paralysis of</i>					
Other conditions..... <i>Senile dementia</i> (Include pregnancy within 8 months of death)					
Major findings or operations..... Date of op.					
Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.					
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of Injury..... Injured at work?					
23. SIGNATURE..... <i>T. L. Mc Gregor</i> M. D. or other Address..... <i>Elkton Md</i> Date signed..... <i>4-27-46</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

63697

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex:

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Auto. Mechanic

11. Industry or business

Wilburn Wiles

MOTHER FATHER

12. Name

North Carolina

13. Birthplace

14. Maiden name

Martha Jane Calvert

15. Birthplace

North Carolina

16. Informant

Mrs Adam Wiles

Address

North East, Md RD

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof Apr 9 1946
(month) (day) (year)

Cemetery or crematory

Cemetery

Location

North Wilkesboro, N.C.

18. Funeral director

Joseph R Grant

Address

North East, Md

19. Date rec'd by registrar

Apr 9 1946

F H Fraser

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

not a Veteran

3. (b) Social Security Number

245-07-5228

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 7 1946 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

Immediate cause of death

Compound fracture
of skull fracture
Articular &
mainly lacerations

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Accident Date of 4-6-46Where did injury occur North East, Md (City or town) (County) (State)

Injured at home, farm, industry, public, place (where?)

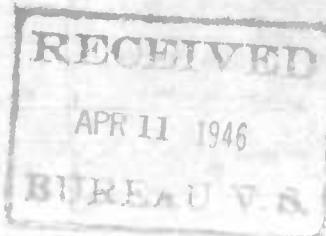
Means of injury Automobile Injured at work?

23. SIGNATURE

Medical Examiner

M. D. or other

Date signed 4-7-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 162

63698

CERTIFICATE OF DEATH

Reg. Date. No. 96

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

B. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal, Where?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date recd by registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 21 1946 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Now April 19 1946 to April 21 1946

and that I last saw her alive on April 18 1946

Immediate cause of death.....

General Haemorrhage DURATION 3 da

Due to.....

General asthmatic 20 yrs

Due to..... Accidental fall - fell on ice, in yard.

Other conditions..... Terminated extra corporal 6 mos

fracture of femur

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Accident Date of Jan 14 1946

Where did injury occur? Port Deposit, Cecil, Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At home residence

Means of injury Accidental fall. Injured at work?

23. SIGNATURE

M. D. or other

Address Perryville Md. Date signed Apr 22 1946

